

107TH CONGRESS
2D SESSION

S. 2736

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with a drug discount card that ensures access to affordable outpatient prescription drugs.

IN THE SENATE OF THE UNITED STATES

JULY 16, 2002

Mr. HAGEL (for himself, Mr. ENSIGN, Mr. LUGAR, Mr. GRAMM, and Mr. INHOFE) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with a drug discount card that ensures access to affordable outpatient prescription drugs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Rx Drug Discount and Security Act of 2002”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Voluntary Medicare Outpatient Prescription Drug Discount and Security Program.

“PART D—VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION DRUG
DISCOUNT AND SECURITY PROGRAM

“Sec. 1860. Definitions.

“Sec. 1860A. Establishment of program.

“Sec. 1860B. Enrollment.

“Sec. 1860C. Providing enrollment and coverage information to beneficiaries.

“Sec. 1860D. Enrollee protections.

“Sec. 1860E. Annual enrollment fee.

“Sec. 1860F. Benefits under the program.

“Sec. 1860G. Selection of entities to provide prescription drug coverage.

“Sec. 1860H. Payments to eligible entities for administering the catastrophic benefit.

“Sec. 1860I. Determination of income levels.

“Sec. 1860J. Appropriations.

“Sec. 1860K. Medicare Competition and Prescription Drug Advisory Board.”.

Sec. 3. Administration of Voluntary Medicare Outpatient Prescription Drug Discount and Security Program.

Sec. 4. Exclusion of part D costs from determination of part B monthly premium.

Sec. 5. Medigap revisions.

1 **SEC. 2. VOLUNTARY MEDICARE OUTPATIENT PRESCRIP-**
2 **TION DRUG DISCOUNT AND SECURITY PRO-**
3 **GRAM.**

4 (a) ESTABLISHMENT OF PROGRAM.—Title XVIII of
5 the Social Security Act (42 U.S.C. 1395 et seq.) is
6 amended—

7 (1) by redesignating part D as part E; and

8 (2) by inserting after part C the following new
9 part:

1 “PART D—VOLUNTARY MEDICARE OUTPATIENT PRE-
 2 SCRIPTION DRUG DISCOUNT AND SECURITY PRO-
 3 GRAM

4 “DEFINITIONS

5 “SEC. 1860. In this part:

6 “(1) COVERED OUTPATIENT DRUG.—

7 “(A) IN GENERAL.—Except as provided in
 8 this paragraph, the term ‘covered outpatient
 9 drug’ means—

10 “(i) a drug that may be dispensed
 11 only upon a prescription and that is de-
 12 scribed in subparagraph (A)(i) or (A)(ii) of
 13 section 1927(k)(2); or

14 “(ii) a biological product described in
 15 clauses (i) through (iii) of subparagraph
 16 (B) of such section or insulin described in
 17 subparagraph (C) of such section,

18 and such term includes a vaccine licensed under
 19 section 351 of the Public Health Service Act
 20 and any use of a covered outpatient drug for a
 21 medically accepted indication (as defined in sec-
 22 tion 1927(k)(6)).

23 “(B) EXCLUSIONS.—

24 “(i) IN GENERAL.—Such term does
 25 not include drugs or classes of drugs, or

1 their medical uses, which may be excluded
 2 from coverage or otherwise restricted
 3 under section 1927(d)(2), other than sub-
 4 paragraph (E) thereof (relating to smoking
 5 cessation agents), or under section
 6 1927(d)(3).

7 “(ii) AVOIDANCE OF DUPLICATE COV-
 8 ERAGE.—A drug prescribed for an indi-
 9 vidual that would otherwise be a covered
 10 outpatient drug under this part shall not
 11 be so considered if payment for such drug
 12 is available under part A or B for an indi-
 13 vidual entitled to benefits under part A
 14 and enrolled under part B.

15 “(C) APPLICATION OF FORMULARY RE-
 16 STRICTIONS.—A drug prescribed for an indi-
 17 vidual that would otherwise be a covered out-
 18 patient drug under this part shall not be so
 19 considered under a plan if the plan excludes the
 20 drug under a formulary and such exclusion is
 21 not successfully appealed under section
 22 1860D(a)(4)(B).

23 “(D) APPLICATION OF GENERAL EXCLU-
 24 SION PROVISIONS.—A prescription drug dis-
 25 count card plan or Medicare+Choice plan may

1 exclude from qualified prescription drug cov-
 2 erage any covered outpatient drug—

3 “(i) for which payment would not be
 4 made if section 1862(a) applied to part D;
 5 or

6 “(ii) which are not prescribed in ac-
 7 cordance with the plan or this part.

8 Such exclusions are determinations subject to
 9 reconsideration and appeal pursuant to section
 10 1860D(a)(4).

11 “(2) ELIGIBLE BENEFICIARY.—The term ‘eligi-
 12 ble beneficiary’ means an individual who is—

13 “(A) eligible for benefits under part A or
 14 enrolled under part B; and

15 “(B) not eligible for prescription drug cov-
 16 erage under a State plan under the medicaid
 17 program under title XIX.

18 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
 19 tity’ means any—

20 “(A) pharmaceutical benefit management
 21 company;

22 “(B) wholesale pharmacy delivery system;

23 “(C) retail pharmacy delivery system;

1 “(D) insurer (including any issuer of a
2 medicare supplemental policy under section
3 1882);

4 “(E) Medicare+Choice organization;

5 “(F) State (in conjunction with a pharma-
6 ceutical benefit management company);

7 “(G) employer-sponsored plan;

8 “(H) other entity that the Secretary deter-
9 mines to be appropriate to provide benefits
10 under this part; or

11 “(I) combination of the entities described
12 in subparagraphs (A) through (H).

13 “(4) OUT-OF-POCKET EXPENSES.—The term
14 ‘out-of-pocket expenses’ means only those expenses
15 for covered outpatient drugs that are incurred by the
16 eligible beneficiary using a card approved by the
17 Secretary under this part that are paid by that bene-
18 ficiary and for which the beneficiary is not reim-
19 bursed (through insurance or otherwise) by another
20 person.

21 “(5) POVERTY LINE.—The term ‘poverty line’
22 means the income official poverty line (as defined by
23 the Office of Management and Budget, and revised
24 annually in accordance with section 673(2) of the

1 Omnibus Budget Reconciliation Act of 1981) appli-
 2 cable to a family of the size involved.

3 “(6) SECRETARY.—The term ‘Secretary’ means
 4 the Secretary of Health and Human Services, acting
 5 through the Administrator of the Centers for Medi-
 6 care & Medicaid Services.

7 “ESTABLISHMENT OF PROGRAM

8 “SEC. 1860A. (a) PROVISION OF BENEFIT.—The
 9 Secretary shall establish a Medicare Outpatient Prescrip-
 10 tion Drug Discount and Security Program under which
 11 the Secretary endorses prescription drug card plans of-
 12 fered by eligible entities in which eligible beneficiaries may
 13 voluntarily enroll and receive benefits under this part.

14 “(b) ENDORSEMENT OF PRESCRIPTION DRUG DIS-
 15 COUNT CARD PLANS.—

16 “(1) IN GENERAL.—The Secretary shall en-
 17 dorse a prescription drug card plan offered by an eli-
 18 gible entity with a contract under this part if the eli-
 19 gible entity meets the requirements of this part with
 20 respect to that plan.

21 “(2) NATIONAL PLANS.—In addition to other
 22 types of plans, the Secretary may endorse national
 23 prescription drug plans under paragraph (1).

24 “(c) VOLUNTARY NATURE OF PROGRAM.—Nothing
 25 in this part shall be construed as requiring an eligible ben-
 26 eficiary to enroll in the program under this part.

1 “(d) FINANCING.—The costs of providing benefits
 2 under this part shall be payable from the Federal Supple-
 3 mentary Medical Insurance Trust Fund established under
 4 section 1841.

5 “ENROLLMENT

6 “SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

7 “(1) ESTABLISHMENT OF PROCESS.—

8 “(A) IN GENERAL.—The Secretary shall
 9 establish a process through which an eligible
 10 beneficiary (including an eligible beneficiary en-
 11 rolled in a Medicare+Choice plan offered by a
 12 Medicare+Choice organization) may make an
 13 election to enroll under this part. Except as
 14 otherwise provided in this subsection, such
 15 process shall be similar to the process for en-
 16 rollment under part B under section 1837.

17 “(B) REQUIREMENT OF ENROLLMENT.—

18 An eligible beneficiary must enroll under this
 19 part in order to be eligible to receive the bene-
 20 fits under this part.

21 “(2) ENROLLMENT PERIODS.—

22 “(A) IN GENERAL.—Except as provided in
 23 this paragraph, an eligible beneficiary may not
 24 enroll in the program under this part during
 25 any period after the beneficiary’s initial enroll-

1 ment period under part B (as determined under
2 section 1837).

3 “(B) SPECIAL ENROLLMENT PERIOD.—In
4 the case of eligible beneficiaries that have re-
5 cently lost eligibility for prescription drug cov-
6 erage under a State plan under the medicaid
7 program under title XIX, the Secretary shall
8 establish a special enrollment period in which
9 such beneficiaries may enroll under this part.

10 “(C) OPEN ENROLLMENT PERIOD IN 2003
11 FOR CURRENT BENEFICIARIES.—The Secretary
12 shall establish a period, which shall begin on
13 the date on which the Secretary first begins to
14 accept elections for enrollment under this part,
15 during which any eligible beneficiary may—

16 “(i) enroll under this part; or

17 “(ii) enroll or reenroll under this part
18 after having previously declined or termi-
19 nated such enrollment.

20 “(3) PERIOD OF COVERAGE.—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (B) and subject to subparagraph
23 (C), an eligible beneficiary’s coverage under the
24 program under this part shall be effective for
25 the period provided under section 1838, as if

1 that section applied to the program under this
2 part.

3 “(B) ENROLLMENT DURING OPEN AND
4 SPECIAL ENROLLMENT.—Subject to subpara-
5 graph (C), an eligible beneficiary who enrolls
6 under the program under this part under sub-
7 paragraph (B) or (C) of paragraph (2) shall be
8 entitled to the benefits under this part begin-
9 ning on the first day of the month following the
10 month in which such enrollment occurs.

11 “(4) PART D COVERAGE TERMINATED BY TER-
12 MINATION OF COVERAGE UNDER PARTS A AND B OR
13 ELIGIBILITY FOR MEDICAL ASSISTANCE.—

14 “(A) IN GENERAL.—In addition to the
15 causes of termination specified in section 1838,
16 the Secretary shall terminate an individual’s
17 coverage under this part if the individual is—

18 “(i) no longer enrolled in part A or B;

19 or

20 “(ii) eligible for prescription drug cov-
21 erage under a State plan under the med-
22 icaid program under title XIX.

23 “(B) EFFECTIVE DATE.—The termination
24 described in subparagraph (A) shall be effective
25 on the effective date of—

1 “(i) the termination of coverage under
2 part A or (if later) under part B; or

3 “(ii) the coverage under title XIX.

4 “(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

5 “(1) PROCESS.—The Secretary shall establish a
6 process through which an eligible beneficiary who is
7 enrolled under this part shall make an annual elec-
8 tion to enroll in a prescription drug card plan of-
9 fered by an eligible entity that has been awarded a
10 contract under this part and serves the geographic
11 area in which the beneficiary resides.

12 “(2) ELECTION PERIODS.—

13 “(A) IN GENERAL.—Except as provided in
14 this paragraph, the election periods under this
15 subsection shall be the same as the coverage
16 election periods under the Medicare+Choice
17 program under section 1851(e), including—

18 “(i) annual coordinated election peri-
19 ods; and

20 “(ii) special election periods.

21 In applying the last sentence of section
22 1851(e)(4) (relating to discontinuance of a
23 Medicare+Choice election during the first year
24 of eligibility) under this subparagraph, in the
25 case of an election described in such section in

1 which the individual had elected or is provided
2 qualified prescription drug coverage at the time
3 of such first enrollment, the individual shall be
4 permitted to enroll in a prescription drug card
5 plan under this part at the time of the election
6 of coverage under the original fee-for-service
7 plan.

8 “(B) INITIAL ELECTION PERIODS.—

9 “(i) INDIVIDUALS CURRENTLY COV-
10 ERED.—In the case of an individual who is
11 entitled to benefits under part A or en-
12 rolled under part B as of November 1,
13 2003, there shall be an initial election pe-
14 riod of 6 months beginning on that date.

15 “(ii) INDIVIDUAL COVERED IN FU-
16 TURE.—In the case of an individual who is
17 first entitled to benefits under part A or
18 enrolled under part B after such date,
19 there shall be an initial election period
20 which is the same as the initial enrollment
21 period under section 1837(d).

22 “(C) ADDITIONAL SPECIAL ELECTION PE-
23 RIODS.—The Administrator shall establish spe-
24 cial election periods—

1 “(i) in cases of individuals who have
 2 and involuntarily lose prescription drug
 3 coverage described in paragraph (3);

4 “(ii) in cases described in section
 5 1837(h) (relating to errors in enrollment),
 6 in the same manner as such section applies
 7 to part B; and

8 “(iii) in the case of an individual who
 9 meets such exceptional conditions (includ-
 10 ing conditions provided under section
 11 1851(e)(4)(D)) as the Secretary may pro-
 12 vide.

13 “(D) ENROLLMENT WITH ONE PLAN
 14 ONLY.—The rules established under subpara-
 15 graph (B) shall ensure that an eligible bene-
 16 ficiary may only enroll in 1 prescription drug
 17 card plan offered by an eligible entity for a
 18 year.

19 “(3) MEDICARE+CHOICE ENROLLEES.—An eli-
 20 gible beneficiary who is enrolled under this part and
 21 enrolled in a Medicare+Choice plan offered by a
 22 Medicare+Choice organization must enroll in a pre-
 23 scription drug discount card plan offered by an eligi-
 24 ble entity in order to receive benefits under this
 25 part. The beneficiary may elect to receive such bene-

1 fits through the Medicare+Choice organization in
 2 which the beneficiary is enrolled if the organization
 3 has been awarded a contract under this part.

4 “(4) CONTINUOUS PRESCRIPTION DRUG COV-
 5 ERAGE.—An individual is considered for purposes of
 6 this part to be maintaining continuous prescription
 7 drug coverage on and after the date the individual
 8 first qualifies to elect prescription drug coverage
 9 under this part if the individual establishes that as
 10 of such date the individual is covered under any of
 11 the following prescription drug coverage and before
 12 the date that is the last day of the 63-day period
 13 that begins on the date of termination of the par-
 14 ticular prescription drug coverage involved (regard-
 15 less of whether the individual subsequently obtains
 16 any of the following prescription drug coverage):

17 “(A) COVERAGE UNDER PRESCRIPTION
 18 DRUG CARD PLAN OR MEDICARE+CHOICE
 19 PLAN.—Prescription drug coverage under a pre-
 20 scription drug card plan under this part or
 21 under a Medicare+Choice plan.

22 “(B) MEDICAID PRESCRIPTION DRUG COV-
 23 ERAGE.—Prescription drug coverage under a
 24 medicaid plan under title XIX, including
 25 through the Program of All-inclusive Care for

the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

“(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage

1 under a medicare supplemental policy under
 2 section 1882 that provides benefits for prescrip-
 3 tion drugs (whether or not such coverage con-
 4 forms to the standards for packages of benefits
 5 under section 1882(p)(1)) and if (subject to
 6 subparagraph (E)(ii)) the coverage provides
 7 benefits at least equivalent to the benefits under
 8 a prescription drug card plan under this part.

9 “(E) STATE PHARMACEUTICAL ASSIST-
 10 ANCE PROGRAM.—Coverage of prescription
 11 drugs under a State pharmaceutical assistance
 12 program, but only if (subject to subparagraph
 13 (E)(ii)) the coverage provides benefits at least
 14 equivalent to the benefits under a prescription
 15 drug card plan under this part.

16 “(F) VETERANS’ COVERAGE OF PRESCRIP-
 17 TION DRUGS.—Coverage of prescription drugs
 18 for veterans under chapter 17 of title 38,
 19 United States Code, but only if (subject to sub-
 20 paragraph (E)(ii)) the coverage provides bene-
 21 fits at least equivalent to the benefits under a
 22 prescription drug card plan under this part.

23 For purposes of carrying out this paragraph, the
 24 certifications of the type described in sections
 25 2701(e) of the Public Health Service Act and in sec-

11 “PROVIDING ENROLLMENT AND COVERAGE INFORMATION
12 TO BENEFICIARIES

“(b) SPECIAL RULE FOR FIRST ENROLLMENT
UNDER THE PROGRAM.—To the extent practicable, the
activities described in subsection (a) shall ensure that eli-
gible beneficiaries are provided with such information at
least 60 days prior to the first enrollment period described
in section 1860B(c).

1 “ENROLLEE PROTECTIONS

2 “SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGI-
3 BLE ENTITIES.—Each eligible entity shall meet the fol-
4 lowing requirements:

5 “(1) GUARANTEED ISSUANCE AND NON-
6 DISCRIMINATION.—

7 “(A) GUARANTEED ISSUANCE.—

8 “(i) IN GENERAL.—An eligible bene-
9 ficiary who is eligible to enroll in a pre-
10 scription drug card plan offered by an eli-
11 gible entity under section 1860B(b) for
12 prescription drug coverage under this part
13 at a time during which elections are ac-
14 cepted under this part with respect to the
15 coverage shall not be denied enrollment
16 based on any health status-related factor
17 (described in section 2702(a)(1) of the
18 Public Health Service Act) or any other
19 factor.

20 “(ii) MEDICARE+CHOICE LIMITA-
21 TIONS PERMITTED.—The provisions of
22 paragraphs (2) and (3) (other than sub-
23 paragraph (C)(i), relating to default enroll-
24 ment) of section 1851(g) (relating to pri-
25 ority and limitation on termination of elec-

tion) shall apply to eligible entities under this subsection.

“(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

“(2) DISCLOSURE OF INFORMATION.—

“(A) INFORMATION.—

“(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

“(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

1 “(I) How enrollees will have ac-
2 cess to covered outpatient drugs, in-
3 cluding access to such drugs through
4 pharmacy networks.

5 “(II) How any formulary used by
6 the eligible entity functions.

7 “(III) Information on grievance
8 and appeals procedures.

9 “(IV) Information on enrollment
10 fees and prices charged to the enrollee
11 for covered outpatient drugs.

12 “(V) Any other information that
13 the Secretary determines is necessary
14 to promote informed choices by eligi-
15 ble beneficiaries among eligible enti-
16 ties.

17 “(B) DISCLOSURE UPON REQUEST OF
18 GENERAL COVERAGE, UTILIZATION, AND GRIEV-
19 ANCE INFORMATION.—Upon request of an eligi-
20 ble beneficiary, the eligible entity shall provide
21 the information described in paragraph (3) to
22 such beneficiary.

23 “(C) RESPONSE TO BENEFICIARY QUES-
24 TIONS.—Each eligible entity offering a prescrip-
25 tion drug discount card plan under this part

1 shall have a mechanism for providing specific
 2 information to enrollees upon request. The enti-
 3 ty shall make available, through an Internet
 4 website and, upon request, in writing, informa-
 5 tion on specific changes in its formulary.

6 “(3) GRIEVANCE MECHANISM, COVERAGE DE-
 7 TERMINATIONS, AND RECONSIDERATIONS.—

8 “(A) IN GENERAL.—With respect to the
 9 benefit under this part, each eligible entity of-
 10 fering a prescription drug discount card plan
 11 shall provide meaningful procedures for hearing
 12 and resolving grievances between the organiza-
 13 tion (including any entity or individual through
 14 which the eligible entity provides covered bene-
 15 fits) and enrollees with prescription drug card
 16 plans of the eligible entity under this part in ac-
 17 cordance with section 1852(f).

18 “(B) APPLICATION OF COVERAGE DETER-
 19 MINATION AND RECONSIDERATION PROVI-
 20 SIONS.—Each eligible entity shall meet the re-
 21 quirements of paragraphs (1) through (3) of
 22 section 1852(g) with respect to covered benefits
 23 under the prescription drug card plan it offers
 24 under this part in the same manner as such re-
 25 quirements apply to a Medicare+Choice organi-

1 zation with respect to benefits it offers under a
 2 Medicare+Choice plan under part C.

3 “(C) REQUEST FOR REVIEW OF TIERED
 4 FORMULARY DETERMINATIONS.—In the case of
 5 a prescription drug card plan offered by an eli-
 6 gible entity that provides for tiered cost-sharing
 7 for drugs included within a formulary and pro-
 8 vides lower cost-sharing for preferred drugs in-
 9 cluded within the formulary, an individual who
 10 is enrolled in the plan may request coverage of
 11 a nonpreferred drug under the terms applicable
 12 for preferred drugs if the prescribing physician
 13 determines that the preferred drug for treat-
 14 ment of the same condition is not as effective
 15 for the individual or has adverse effects for the
 16 individual.

17 “(4) APPEALS.—

18 “(A) IN GENERAL.—Subject to subpara-
 19 graph (B), each eligible entity offering a pre-
 20 scription drug card plan shall meet the require-
 21 ments of paragraphs (4) and (5) of section
 22 1852(g) with respect to drugs not included on
 23 any formulary in the same manner as such re-
 24 quirements apply to a Medicare+Choice organi-

1 zation with respect to benefits it offers under a
2 Medicare+Choice plan under part C.

3 “(B) FORMULARY DETERMINATIONS.—An
4 individual who is enrolled in a prescription drug
5 card plan offered by an eligible entity may ap-
6 peal to obtain coverage under this part for a
7 covered outpatient drug that is not on a for-
8 mulary of the eligible entity if the prescribing
9 physician determines that the formulary drug
10 for treatment of the same condition is not as
11 effective for the individual or has adverse ef-
12 fects for the individual.

13 “(5) CONFIDENTIALITY AND ACCURACY OF EN-
14 ROLLEE RECORDS.—Each eligible entity offering a
15 prescription drug discount card plan shall meet the
16 requirements of the Health Insurance Portability
17 and Accountability Act of 1996.

18 (b) ELIGIBLE ENTITIES OFFERING A DISCOUNT
19 CARD PROGRAM.—If an eligible entity offers a discount
20 card program under this part, in addition to the require-
21 ments under subsection (a), the entity shall meet the fol-
22 lowing requirements:

23 “(1) ACCESS TO COVERED BENEFITS.—

24 “(A) ASSURING PHARMACY ACCESS.—

1 “(i) IN GENERAL.—The eligible entity
2 offering the prescription drug discount
3 card plan shall secure the participation in
4 its network of a sufficient number of phar-
5 macies that dispense (other than by mail
6 order) drugs directly to patients to ensure
7 convenient access (as determined by the
8 Secretary and including adequate emer-
9 gency access) for enrolled beneficiaries, in
10 accordance with standards established
11 under section 1860D(a)(3) that ensure
12 such convenient access.

13 “(ii) USE OF POINT-OF-SERVICE SYS-
14 TEM.—Each eligible entity offering a pre-
15 scription drug discount card plan shall es-
16 tablish an optional point-of-service method
17 of operation under which—

18 “(I) the plan provides access to
19 any or all pharmacies that are not
20 participating pharmacies in its net-
21 work; and

22 “(II) discounts under the plan
23 may not be available.

1 The additional copayments so charged
2 shall not be counted as out-of-pocket ex-
3 penses for purposes of section 1860F(b).

4 “(B) USE OF STANDARDIZED TECH-
5 NOLOGY.—

6 “(i) IN GENERAL.—Each eligible enti-
7 ty offering a prescription drug discount
8 card plan shall issue (and reissue, as ap-
9 propriate) such a card (or other tech-
10 nology) that may be used by an enrolled
11 beneficiary to assure access to negotiated
12 prices under section 1860F(a) for the pur-
13 chase of prescription drugs for which cov-
14 erage is not otherwise provided under the
15 prescription drug discount card plan.

16 “(ii) STANDARDS.—The Secretary
17 shall provide for the development of na-
18 tional standards relating to a standardized
19 format for the card or other technology re-
20 ferred to in subparagraph (A). Such stand-
21 ards shall be compatible with standards es-
22 tablished under part C of title XI.

23 “(C) REQUIREMENTS ON DEVELOPMENT
24 AND APPLICATION OF FORMULARIES.—If an eli-
25 gible entity that offers a prescription drug dis-

count card plan uses a formulary, the following requirements must be met:

“(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

“(ii) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

1 “(iii) INCLUSION OF DRUGS IN ALL
2 THERAPEUTIC CATEGORIES.—The for-
3 mulary must include drugs within each
4 therapeutic category and class of covered
5 outpatient drugs (although not necessarily
6 for all drugs within such categories and
7 classes).

8 “(iv) PROVIDER EDUCATION.—The
9 committee shall establish policies and pro-
10 cedures to educate and inform health care
11 providers concerning the formulary.

12 “(v) NOTICE BEFORE REMOVING
13 DRUGS FROM FORMULARY.—Any removal
14 of a drug from a formulary shall take ef-
15 fect only after appropriate notice is made
16 available to beneficiaries and physicians.

17 “(vi) GRIEVANCES AND APPEALS RE-
18 LATING TO APPLICATION OF
19 FORMULARIES.—For provisions relating to
20 grievances and appeals of coverage, see
21 subsections (e) and (f).

22 “(2) COST AND UTILIZATION MANAGEMENT;
23 QUALITY ASSURANCE; MEDICATION THERAPY MAN-
24 AGEMENT PROGRAM.—

1 “(A) IN GENERAL.—Each eligible entity
2 offering a prescription drug discount card plan
3 may have in place with respect to covered out-
4 patient drugs—

5 “(i) an effective cost and drug utiliza-
6 tion management program, including medi-
7 cally appropriate incentives to use generic
8 drugs and therapeutic interchange, when
9 appropriate;

10 “(ii) quality assurance measures and
11 systems to reduce medical errors and ad-
12 verse drug interactions, including a medi-
13 cation therapy management program de-
14 scribed in subparagraph (B) and an elec-
15 tronic prescription program described in
16 subparagraph (C); and

17 “(iii) a program to control fraud,
18 abuse, and waste.

19 Nothing in this section shall be construed as
20 impairing an eligible entity from applying cost
21 management tools (including differential pay-
22 ments) under all methods of operation.

23 “(B) MEDICATION THERAPY MANAGEMENT
24 PROGRAM.—

1 “(i) IN GENERAL.—A medication
2 therapy management program described in
3 this paragraph is a program of drug ther-
4 apy management and medication adminis-
5 tration that is designed to ensure, with re-
6 spect to beneficiaries with chronic diseases
7 (such as diabetes, asthma, hypertension,
8 and congestive heart failure) or multiple
9 prescriptions, that covered outpatient
10 drugs under the prescription drug discount
11 card plan are appropriately used to achieve
12 therapeutic goals and reduce the risk of
13 adverse events, including adverse drug
14 interactions.

15 “(ii) ELEMENTS.—Such program may
16 include—

17 “(I) enhanced beneficiary under-
18 standing of such appropriate use
19 through beneficiary education, coun-
20 seling, and other appropriate means;

21 “(II) increased beneficiary adher-
22 ence with prescription medication
23 regimens through medication refill re-
24 minders, special packaging, and other
25 appropriate means; and

1 “(III) detection of patterns of
2 overuse and underuse of prescription
3 drugs.

4 “(iii) DEVELOPMENT OF PROGRAM IN
5 COOPERATION WITH LICENSED PHAR-
6 MACISTS.—The program shall be developed
7 in cooperation with licensed pharmacists
8 and physicians.

9 “(iv) CONSIDERATIONS IN PHARMACY
10 FEES.—Each eligible entity offering a pre-
11 scription drug discount card plan shall
12 take into account, in establishing fees for
13 pharmacists and others providing services
14 under the medication therapy management
15 program, the resources and time used in
16 implementing the program.

17 “(C) TREATMENT OF ACCREDITATION.—
18 Section 1852(e)(4) (relating to treatment of ac-
19 creditation) shall apply to prescription drug dis-
20 count card plans under this part with respect to
21 the following requirements, in the same manner
22 as they apply to Medicare+Choice plans under
23 part C with respect to the requirements de-
24 scribed in a clause of section 1852(e)(4)(B):

1 “(i) Paragraph (1) (including quality
 2 assurance), including any medication ther-
 3 apy management program under para-
 4 graph (2).

5 “(ii) Subsection (c)(1) (relating to ac-
 6 cess to covered benefits).

7 “(iii) Subsection (g) (relating to con-
 8 fidentiality and accuracy of enrollee
 9 records).

10 “(D) PUBLIC DISCLOSURE OF PHARMA-
 11 CEUTICAL PRICES FOR EQUIVALENT DRUGS.—
 12 Each eligible entity offering a prescription drug
 13 discount card plan shall provide that each phar-
 14 macy or other dispenser that arranges for the
 15 dispensing of a covered outpatient drug shall
 16 inform the beneficiary at the time of purchase
 17 of the drug of any differential between the price
 18 of the prescribed drug to the enrollee and the
 19 price of the lowest cost generic drug covered
 20 under the plan that is therapeutically equivalent
 21 and bioequivalent.

22 “ANNUAL ENROLLMENT FEE

23 “SEC. 1860E. (a) AMOUNT.—

24 “(1) IN GENERAL.—Except as provided in sub-
 25 section (c), enrollment under the program under this

1 part is conditioned upon payment of an annual en-
 2 rollment fee of \$25.

3 “(2) ANNUAL PERCENTAGE INCREASE.—

4 “(A) IN GENERAL.—In the case of any cal-
 5 endar year beginning after 2004, the dollar
 6 amount in paragraph (1) shall be increased by
 7 an amount equal to—

8 “(i) such dollar amount; multiplied by

9 “(ii) the inflation adjustment.

10 “(B) INFLATION ADJUSTMENT.—For pur-
 11 poses of subparagraph (A)(ii), the inflation ad-
 12 justment for any calendar year is the percent-
 13 age (if any) by which—

14 “(i) the average per capita aggregate
 15 expenditures for covered outpatient drugs
 16 in the United States for medicare bene-
 17 ficiaries, as determined by the Secretary
 18 for the 12-month period ending in July of
 19 the previous year; exceeds

20 “(ii) such aggregate expenditures for
 21 the 12-month period ending with July
 22 2003.

23 “(C) ROUNDING.—If any increase deter-
 24 mined under clause (ii) is not a multiple of \$1,

1 such increase shall be rounded to the nearest
2 multiple of \$1.

3 “(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

4 “(1) IN GENERAL.—Unless the eligible bene-
5 ficiary makes an election under paragraph (2), the
6 annual enrollment fee described in subsection (a)
7 shall be collected and credited to the Federal Sup-
8 plementary Medical Insurance Trust Fund in the
9 same manner as the monthly premium determined
10 under section 1839 is collected and credited to such
11 Trust Fund under section 1840.

12 “(2) DIRECT PAYMENT.—An eligible beneficiary
13 may elect to pay the annual enrollment fee directly
14 or in any other manner approved by the Secretary.
15 The Secretary shall establish procedures for making
16 such an election.

17 “(c) WAIVER.—The Secretary shall waive the enroll-
18 ment fee described in subsection (a) in the case of an eligi-
19 ble beneficiary whose income is below 200 percent of the
20 poverty line.

21 “BENEFITS UNDER THE PROGRAM

22 “SEC. 1860F. (a) ACCESS TO NEGOTIATED
23 PRICES.—

24 “(1) NEGOTIATED PRICES.—

25 “(A) IN GENERAL.—Subject to subpara-
26 graph (B), each prescription drug card plan of-

fering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term ‘prescription drugs’ is not limited to covered outpatient drugs, but does not include any over-the-counter drug that is not a covered outpatient drug.

“(B) LIMITATIONS.—

“(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

1 “(ii) AVOIDANCE OF DUPLICATE COV-
 2 ERAGE.—The negotiated prices (including
 3 applicable discounts) for prescription drugs
 4 shall not be available for any drug pre-
 5 scribed for an eligible beneficiary if pay-
 6 ment for the drug is available under part
 7 A or B (but such negotiated prices shall be
 8 available if payment under part A or B is
 9 not available because the beneficiary has
 10 not met the deductible or has exhausted
 11 benefits under part A or B).

12 “(2) DISCOUNT CARD.—The Secretary shall de-
 13 velop a uniform standard card format to be issued
 14 by each eligible entity offering a prescription drug
 15 discount card plan that shall be used by an enrolled
 16 beneficiary to ensure the access of such beneficiary
 17 to negotiated prices under paragraph (1).

18 “(3) ENSURING DISCOUNTS IN ALL AREAS.—
 19 The Secretary shall develop procedures that ensure
 20 that each eligible beneficiary that resides in an area
 21 where no prescription drug discount card plans are
 22 available is provided with access to negotiated prices
 23 for prescription drugs (including applicable dis-
 24 counts).

25 “(b) CATASTROPHIC BENEFIT.—

1 “(1) IN GENERAL.—Subject to paragraph (4)
2 (relating to eligibility for the catastrophic benefit)
3 and any formulary used by the prescription drug dis-
4 count card program in which the eligible beneficiary
5 is enrolled, the catastrophic benefit shall be adminis-
6 tered as follows:

7 “(A) BENEFICIARIES WITH ANNUAL IN-
8 COMES BELOW 200 PERCENT OF THE POVERTY
9 LINE.—In the case of an eligible beneficiary
10 whose modified adjusted gross income (as de-
11 fined in paragraph (4)(E)) is below 200 percent
12 of the poverty line, the beneficiary shall not be
13 responsible for making a payment for a covered
14 outpatient drug provided under this part to the
15 beneficiary in a year to the extent that the out-
16 of-pocket expenses of the beneficiary for such
17 drug exceed \$1,500, unless the Secretary imple-
18 ments cost-sharing (as authorized under this
19 part).

20 “(B) BENEFICIARIES WITH ANNUAL IN-
21 COMES BETWEEN 200 AND 400 PERCENT OF THE
22 POVERTY LINE.—In the case of an eligible ben-
23 eficiary whose modified adjusted gross income
24 (as so defined) equals or exceeds 200 percent,
25 but does not exceed 400 percent, of the poverty

1 line, the beneficiary shall not be responsible for
2 making a payment for a covered outpatient
3 drug provided under this part to the beneficiary
4 in a year to the extent that the out-of-pocket
5 expenses of the beneficiary for such drug exceed
6 \$3,500, unless the Secretary implements cost-
7 sharing (as authorized under this part).

8 “(C) BENEFICIARIES WITH ANNUAL IN-
9 COMES BETWEEN 400 AND 600 PERCENT OF THE
10 POVERTY LINE.—In the case of an eligible ben-
11 eficiary whose modified adjusted gross income
12 (as so defined) equals or exceeds 400 percent,
13 but does not exceed 600 percent, of the poverty
14 line, the beneficiary shall not be responsible for
15 making a payment for a covered outpatient
16 drug provided under this part to the beneficiary
17 in a year to the extent that the out-of-pocket
18 expenses of the beneficiary for such drug exceed
19 \$5,500, unless the Secretary implements cost-
20 sharing (as authorized under this part).

21 “(D) BENEFICIARIES WITH ANNUAL IN-
22 COMES THAT EXCEED 600 PERCENT OF THE
23 POVERTY LINE.—In the case of an eligible ben-
24 eficiary whose modified adjusted gross income
25 (as so defined) equals or exceeds 600 percent of

the poverty line, the beneficiary shall not be responsible for making a payment for a covered outpatient drug provided under this part to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug exceeds 20 percent of that beneficiary's income, unless the Secretary implements cost-sharing (as authorized under this part).

“(2) ANNUAL PERCENTAGE INCREASE.—

“(A) IN GENERAL.—In the case of any calendar year after 2004, the dollar amounts in paragraph (1) shall be increased by an amount equal to—

“(i) such dollar amount; multiplied by

“(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

“(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of \$1, such increase shall be rounded to the nearest multiple of \$1.

“(3) ELIGIBLE ENTITY NOT AT RISK FOR CATASTROPHIC BENEFIT.—

“(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at risk for the

1 provision of the catastrophic benefit under this
 2 subsection.

3 “(B) PROVISIONS RELATING TO PAYMENTS
 4 TO ELIGIBLE ENTITIES.—For provisions relat-
 5 ing to payments to eligible entities for admin-
 6 istering the catastrophic benefit under this sub-
 7 section, see section 1860H.

8 “(C) PROCEDURES FOR DETERMINING
 9 MODIFIED ADJUSTED GROSS INCOME.—

10 “(i) IN GENERAL.—The Secretary
 11 shall establish procedures for determining
 12 the modified adjusted gross income of eligi-
 13 ble beneficiaries enrolled under this part.

14 “(ii) CONSULTATION.—The Secretary
 15 shall consult with the Secretary of the
 16 Treasury in making the determinations de-
 17 scribed in clause (i).

18 “(iii) DISCLOSURE OF INFORMA-
 19 TION.—Notwithstanding section 6103(a) of
 20 the Internal Revenue Code of 1986, the
 21 Secretary of the Treasury may, upon writ-
 22 ten request from the Secretary, disclose to
 23 officers and employees of the Centers for
 24 Medicare & Medicaid Services such return
 25 information as is necessary to make the

determinations described in clause (i). Return information disclosed under the preceding sentence may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary, in making such determinations.

“(D) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—In this paragraph, the term ‘modified adjusted gross income’ means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

“(i) determined without regard to sections 135, 911, 931, and 933 of such Code;

“(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code; and

“(iii) increased by any amount received under title II.

“(5) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that re-

1 sides in an area where there are no prescription
 2 drug discount card plans offered that have been
 3 awarded a contract under this part.

4 “REQUIREMENTS FOR ENTITIES TO PROVIDE
 5 PRESCRIPTION DRUG COVERAGE

6 “SEC. 1860G. (a) ESTABLISHMENT OF BIDDING
 7 PROCESS.—The Secretary shall establish a process under
 8 which the Secretary accepts bids from eligible entities and
 9 awards contracts to the entities to provide the benefits
 10 under this part to eligible beneficiaries in an area.

11 “(b) SUBMISSION OF BIDS.—Each eligible entity de-
 12 siring to enter into a contract under this part shall submit
 13 a bid to the Secretary at such time, in such manner, and
 14 accompanied by such information as the Secretary may
 15 require.

16 “(c) ADMINISTRATIVE FEE BID.—

17 “(1) SUBMISSION.—For the bid described in
 18 subsection (b), each entity shall submit to the Sec-
 19 retary information regarding administration of the
 20 discount card and catastrophic benefit under this
 21 part.

22 “(2) BID SUBMISSION REQUIREMENTS.—

23 “(A) ADMINISTRATIVE FEE BID SUBMIS-
 24 SION.—In submitting bids, the entities shall in-
 25 clude separate costs for administering the dis-
 26 count card component, if applicable, and the

1 catastrophic benefit. The entity shall submit the
 2 administrative fee bid in a form and manner
 3 specified by the Secretary, and shall include a
 4 statement of projected enrollment and a sepa-
 5 rate statement of the projected administrative
 6 costs for at least the following functions:

7 “(i) Enrollment, including income eli-
 8 gibility determination.

9 “(ii) Claims processing.

10 “(iii) Quality assurance, including
 11 drug utilization review.

12 “(iv) Beneficiary and pharmacy cus-
 13 tomer service.

14 “(v) Coordination of benefits.

15 “(vi) Fraud and abuse prevention.

16 “(B) NEGOTIATED ADMINISTRATIVE FEE
 17 BID AMOUNTS.—The Secretary has the author-
 18 ity to negotiate regarding the bid amounts sub-
 19 mitted. The Secretary may reject a bid if the
 20 Secretary determines it is not supported by the
 21 administrative cost information provided in the
 22 bid as specified in subparagraph (A).

23 “(C) PAYMENT TO PLANS BASED ON AD-
 24 MINISTRATIVE FEE BID AMOUNTS.—The Sec-
 25 retary shall use the bid amounts to calculate a

1 benchmark amount consisting of the enroll-
 2 ment-weighted average of all bids for each func-
 3 tion and each class of entity. The class of entity
 4 is either a regional or national entity, or such
 5 other classes as the Secretary may determine to
 6 be appropriate. The functions are the discount
 7 card and catastrophic components. If an eligible
 8 entity's combined bid for both functions is
 9 above the combined benchmark within the enti-
 10 ty's class for the functions, the eligible entity
 11 shall collect additional necessary revenue
 12 through one or both of the following:

13 “(i) Additional fees charged to the
 14 beneficiary, not to exceed \$25 annually.

15 “(ii) Use of rebate amounts from drug
 16 manufacturers to defray administrative
 17 costs.

18 “(d) AWARDING OF CONTRACTS.—

19 “(1) IN GENERAL.—The Secretary shall, con-
 20 sistent with the requirements of this part and the
 21 goal of containing medicare program costs, award at
 22 least 2 contracts in each area, unless only 1 bidding
 23 entity meets the terms and conditions specified by
 24 the Secretary under paragraph (2).

1 “(2) TERMS AND CONDITIONS.—The Secretary
 2 shall not award a contract to an eligible entity under
 3 this section unless the Secretary finds that the eligi-
 4 ble entity is in compliance with such terms and con-
 5 ditions as the Secretary shall specify.

6 “(3) REQUIREMENTS FOR ELIGIBLE ENTITIES
 7 PROVIDING DISCOUNT CARD PROGRAM.—Except as
 8 provided in subsection (e), in determining which of
 9 the eligible entities that submitted bids that meet
 10 the terms and conditions specified by the Secretary
 11 under paragraph (2) to award a contract, the Sec-
 12 retary shall consider whether the bid submitted by
 13 the entity meets at least the following requirements:

14 “(A) LEVEL OF SAVINGS TO MEDICARE
 15 BENEFICIARIES.—The program passes on to
 16 medicare beneficiaries who enroll in the pro-
 17 gram discounts on prescription drugs, including
 18 discounts negotiated with manufacturers.

19 “(B) PROHIBITION ON APPLICATION ONLY
 20 TO MAIL ORDER.—The program applies to
 21 drugs that are available other than solely
 22 through mail order and provides convenient ac-
 23 cess to retail pharmacies.

24 “(C) LEVEL OF BENEFICIARY SERVICES.—
 25 The program provides pharmaceutical support

1 services, such as education and services to pre-
2 vent adverse drug interactions.

3 “(D) ADEQUACY OF INFORMATION.—The
4 program makes available to medicare bene-
5 ficiaries through the Internet and otherwise in-
6 formation, including information on enrollment
7 fees, prices charged to beneficiaries, and serv-
8 ices offered under the program, that the Sec-
9 retary identifies as being necessary to provide
10 for informed choice by beneficiaries among en-
11 dorsed programs.

12 “(E) EXTENT OF DEMONSTRATED EXPERI-
13 ENCE.—The entity operating the program has
14 demonstrated experience and expertise in oper-
15 ating such a program or a similar program.

16 “(F) EXTENT OF QUALITY ASSURANCE.—
17 The entity has in place adequate procedures for
18 assuring quality service under the program.

19 “(G) OPERATION OF ASSISTANCE PRO-
20 GRAM.—The entity meets such requirements re-
21 lating to solvency, compliance with financial re-
22 porting requirements, audit compliance, and
23 contractual guarantees as specified by the Sec-
24 retary.

1 “(H) PRIVACY COMPLIANCE.—The entity
 2 implements policies and procedures to safe-
 3 guard the use and disclosure of program bene-
 4 ficiaries’ individually identifiable health infor-
 5 mation in a manner consistent with the Federal
 6 regulations (concerning the privacy of individ-
 7 ually identifiable health information) promul-
 8 gated under section 264(c) of the Health Insur-
 9 ance Portability and Accountability Act of
 10 1996.

11 “(I) ADDITIONAL BENEFICIARY PROTEC-
 12 TIONS.—The program meets such additional re-
 13 quirements as the Secretary identifies to protect
 14 and promote the interest of medicare bene-
 15 ficiaries, including requirements that ensure
 16 that beneficiaries are not charged more than
 17 the lower of the negotiated retail price or the
 18 usual and customary price.

19 The prices negotiated by a prescription drug dis-
 20 count card program endorsed under this section
 21 shall (notwithstanding any other provision of law)
 22 not be taken into account for the purposes of estab-
 23 lishing the best price under section 1927(c)(1)(C).

24 “(4) BENEFICIARY ACCESS TO SAVINGS AND
 25 REBATES.—The Secretary shall require eligi-

1 ties offering a discount card program to pass on sav-
 2 ings and rebates negotiated with manufacturers to
 3 eligible beneficiaries enrolled with the entity.

4 “(5) NEGOTIATED AGREEMENTS WITH EM-
 5 PLOYER-SPONSORED PLANS.—Notwithstanding any
 6 other provision of this part, the Secretary may nego-
 7 tiate agreements with employer-sponsored plans
 8 under which eligible beneficiaries are provided with
 9 a benefit for prescription drug coverage that is more
 10 generous than the benefit that would otherwise have
 11 been available under this part if such an agreement
 12 results in cost savings to the Federal Government.

13 “(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTI-
 14 TIES.—If an eligible entity is licensed under State law to
 15 provide the benefit under this section, such entity shall
 16 not be required to meet the requirements of subsection
 17 (d)(3). If an eligible entity offers a national plan, such
 18 entity shall not be required to meet the requirements of
 19 subsection (d)(3), but shall meet the requirements of Em-
 20 ployee Retirement Income Security Act of 1974 that apply
 21 with respect to such plan.

22 “PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING
 23 THE CATASTROPHIC BENEFIT

24 “SEC. 1860H. (a) IN GENERAL.—The Secretary may
 25 establish procedures for making payments to an eligible
 26 entity under a contract entered into under this part for—

1 “(1) no less than 90 percent of the costs of pro-
 2 viding covered outpatient prescription drugs to bene-
 3 ficiaries eligible for the benefit under this part in ac-
 4 cordance with subsection (b); and

5 “(2) costs incurred by the entity in admin-
 6 istering the catastrophic benefit in accordance with
 7 section 1860G.

8 “(b) PAYMENT FOR COVERED OUTPATIENT PRE-
 9 SCRIPTION DRUGS.—

10 “(1) IN GENERAL.—Except as provided in sub-
 11 section (c) and subject to paragraph (2), the Sec-
 12 retary may only pay an eligible entity for covered
 13 outpatient drugs furnished by the eligible entity to
 14 an eligible beneficiary enrolled with such entity
 15 under this part that is eligible for the catastrophic
 16 benefit under section 1860F(b).

17 “(2) LIMITATIONS.—

18 “(A) FORMULARY RESTRICTIONS.—Insofar
 19 as an eligible entity with a contract under this
 20 part uses a formulary, the Secretary may not
 21 make any payment for a covered outpatient
 22 drug that is not included in such formulary, ex-
 23 cept to the extent provided under section
 24 1860D(a)(4)(B).

1 “(B) NEGOTIATED PRICES.—The Sec-
2 retary may not pay an amount for a covered
3 outpatient drug furnished to an eligible bene-
4 ficiary that exceeds the negotiated price (includ-
5 ing applicable discounts) that the beneficiary
6 would have been responsible for under section
7 1860F(a) or the price negotiated for insurance
8 coverage under the Medicare+Choice program
9 under part C, a medicare supplemental policy,
10 employer-sponsored coverage, or a State plan.

11 “(C) COST-SHARING LIMITATIONS.—An el-
12 igible entity may not charge an individual en-
13 rolled with such entity who is eligible for the
14 catastrophic benefit under this part any copay-
15 ment, tiered copayment, coinsurance, or other
16 cost-sharing that exceeds 10 percent of the cost
17 of the drug that is dispensed to the individual.

18 “(3) PAYMENT IN COMPETITIVE AREAS.—In a
19 geographic area in which 2 or more eligible entities
20 offer a plan under this part, the Secretary may ne-
21 gotiate an agreement with the entity to reimburse
22 the entity for costs incurred in providing the benefit
23 under this part on a capitated basis.

1 “(c) SECONDARY PAYER PROVISIONS.—The provi-
 2 sions of section 1862(b) shall apply to the benefits pro-
 3 vided under this part.

4 “DETERMINATION OF INCOME LEVELS

5 “SEC. 1860I. (a) DETERMINATION OF INCOME LEV-
 6 ELS.—

7 “(1) IN GENERAL.—The Secretary, in consulta-
 8 tion with the Secretary of the Treasury, shall estab-
 9 lish procedures under which each eligible entity
 10 awarded a contract under this part determines the
 11 income levels of eligible beneficiaries enrolled in a
 12 prescription drug card plan offered by that entity at
 13 least annually for purposes of sections 1860E(c) and
 14 1860F(b).

15 “(2) PROCEDURES.—

16 “(A) IN GENERAL.—Except as provided in
 17 subparagraph (B), the procedures established
 18 under paragraph (1) shall—

19 “(i) require each eligible beneficiary
 20 who is enrolled in a prescription drug card
 21 plan to present the Federal income tax re-
 22 turn for the preceding taxable year to the
 23 eligible entity offering the plan as proof of
 24 income for that year;

25 “(ii) require, upon the request of an
 26 eligible entity, the Secretary of the Treas-

1 ury to confirm the amount of income re-
 2 ported on such a Federal income tax re-
 3 turn; and

4 “(iii) attribute, in the case of a joint
 5 return, $\frac{1}{2}$ of the income reported on the
 6 return to each eligible beneficiary filing
 7 such a return.

8 “(B) OTHER PROOF OF INCOME.—If an eligible
 9 beneficiary did not file a Federal income tax return
 10 for the preceding year, if such beneficiary experi-
 11 ences a significant decrease in income during a year,
 12 or if such other circumstances exist as the Secretary
 13 may specify, an eligible beneficiary may submit an
 14 affidavit and such supporting documents as the Sec-
 15 retary may require as proof of the income of that
 16 beneficiary instead of a Federal income tax return.

17 “(b) ENFORCEMENT OF INCOME DETERMINA-
 18 TIONS.—The Secretary, in consultation with the Secretary
 19 of the Treasury, shall—

20 “(1) establish procedures that ensure that eligi-
 21 ble beneficiaries comply with sections 1860E(c) and
 22 1860F(b); and

23 “(2) require, if the Secretary determines that
 24 payments were made under this part to which an eli-

1 gible beneficiary was not entitled, the repayment of
2 any excess payments with interest and a penalty.

3 “(c) QUALITY CONTROL SYSTEM.—

4 “(1) ESTABLISHMENT.—The Secretary shall es-
5 tablish a quality control system to monitor income
6 determinations made by eligible entities under this
7 section and to produce appropriate and comprehen-
8 sive measures of error rates.

9 “(2) PERIODIC AUDITS.—The Inspector General
10 of the Department of Health and Human Services
11 shall conduct periodic audits to ensure that the sys-
12 tem established under paragraph (1) is functioning
13 appropriately.

14 “APPROPRIATIONS

15 “SEC. 1860J. There are authorized to be appro-
16 priated from time to time, out of any moneys in the Treas-
17 ury not otherwise appropriated, to the Federal Supple-
18 mentary Medical Insurance Trust Fund established under
19 section 1841, an amount equal to the amount by which
20 the benefits and administrative costs of providing the ben-
21 efits under this part exceed the enrollment fees collected
22 under section 1860E.

1 “MEDICARE COMPETITION AND PRESCRIPTION DRUG
2 ADVISORY BOARD

3 “SEC. 1860K. (a) ESTABLISHMENT OF BOARD.—

4 There is established a Medicare Prescription Drug Advi-
5 sory Board (in this section referred to as the ‘Board’).

6 “(b) ADVICE ON POLICIES; REPORTS.—

7 “(1) ADVICE ON POLICIES.—The Board shall
8 advise the Secretary on policies relating to the Medi-
9 care Outpatient Prescription Drug Discount and Se-
10 curity Program under this part.

11 “(2) REPORTS.—

12 “(A) IN GENERAL.—With respect to mat-
13 ters of the administration of the program under
14 this part, the Board shall submit to Congress
15 and to the Secretary such reports as the Board
16 determines appropriate. Each such report may
17 contain such recommendations as the Board de-
18 termines appropriate for legislative or adminis-
19 trative changes to improve the administration of
20 the program under this part. Each such report
21 shall be published in the Federal Register.

22 “(B) MAINTAINING INDEPENDENCE OF
23 BOARD.—The Board shall directly submit to
24 Congress reports required under subparagraph
25 (A). No officer or agency of the United States

1 may require the Board to submit to any officer
 2 or agency of the United States for approval,
 3 comments, or review, prior to the submission to
 4 Congress of such reports.

5 “(c) STRUCTURE AND MEMBERSHIP OF THE
 6 BOARD.—

7 “(1) MEMBERSHIP.—The Board shall be com-
 8 posed of 7 members who shall be appointed as fol-
 9 lows:

10 “(A) PRESIDENTIAL APPOINTMENTS.—

11 “(i) IN GENERAL.—Three members
 12 shall be appointed by the President, by and
 13 with the advice and consent of the Senate.

14 “(ii) LIMITATION.—Not more than 2
 15 such members may be from the same polit-
 16 ical party.

17 “(B) SENATORIAL APPOINTMENTS.—Two
 18 members (each member from a different polit-
 19 ical party) shall be appointed by the President
 20 pro tempore of the Senate with the advice of
 21 the Chairman and the Ranking Minority Mem-
 22 ber of the Committee on Finance of the Senate.

23 “(C) CONGRESSIONAL APPOINTMENTS.—
 24 Two members (each member from a different
 25 political party) shall be appointed by the Speak-

1 er of the House of Representatives, with the ad-
2 vice of the Chairman and the Ranking Minority
3 Member of the Committee on Ways and Means
4 of the House of Representatives.

5 “(2) QUALIFICATIONS.—The members shall be
6 chosen on the basis of their integrity, impartiality,
7 and good judgment, and shall be individuals who
8 are, by reason of their education, experience, and at-
9 tainments, exceptionally qualified to perform the du-
10 ties of members of the Board.

11 “(3) COMPOSITION.—Of the members appointed
12 under paragraph (1)—

13 “(A) at least one shall represent the phar-
14 maceutical industry;

15 “(B) at least one shall represent physi-
16 cians;

17 “(C) at least one shall represent medicare
18 beneficiaries;

19 “(D) at least one shall represent practicing
20 pharmacists; and

21 “(E) at least one shall represent eligible
22 entities.

23 “(d) TERMS OF APPOINTMENT.—

1 “(1) IN GENERAL.—Subject to paragraph (2),
 2 each member of the Board shall serve for a term of
 3 6 years.

4 “(2) CONTINUANCE IN OFFICE AND STAGGERED
 5 TERMS.—

6 “(A) CONTINUANCE IN OFFICE.—A mem-
 7 ber appointed to a term of office after the com-
 8 mencement of such term may serve under such
 9 appointment only for the remainder of such
 10 term.

11 “(B) STAGGERED TERMS.—The terms of
 12 service of the members initially appointed under
 13 this section shall begin on January 1, 2004,
 14 and expire as follows:

15 “(i) PRESIDENTIAL APPOINTMENTS.—
 16 The terms of service of the members ini-
 17 tially appointed by the President shall ex-
 18 pire as designated by the President at the
 19 time of nomination, 1 each at the end of—

20 “(I) 2 years;

21 “(II) 4 years; and

22 “(III) 6 years.

23 “(ii) SENATORIAL APPOINTMENTS.—
 24 The terms of service of members initially
 25 appointed by the President pro tempore of

1 the Senate shall expire as designated by
 2 the President pro tempore of the Senate at
 3 the time of nomination, 1 each at the end
 4 of—

5 “(I) 3 years; and

6 “(II) 6 years.

7 “(iii) CONGRESSIONAL APPOINT-
 8 MENTS.—The terms of service of members
 9 initially appointed by the Speaker of the
 10 House of Representatives shall expire as
 11 designated by the Speaker of the House of
 12 Representatives at the time of nomination,
 13 1 each at the end of—

14 “(I) 4 years; and

15 “(II) 5 years.

16 “(C) REAPPOINTMENTS.—Any person ap-
 17 pointed as a member of the Board may not
 18 serve for more than 8 years.

19 “(D) VACANCIES.—Any member appointed
 20 to fill a vacancy occurring before the expiration
 21 of the term for which the member’s predecessor
 22 was appointed shall be appointed only for the
 23 remainder of that term. A member may serve
 24 after the expiration of that member’s term until
 25 a successor has taken office. A vacancy in the

1 Board shall be filled in the manner in which the
2 original appointment was made.

3 “(e) CHAIRPERSON.—A member of the Board shall
4 be designated by the President to serve as Chairperson
5 for a term of 4 years, coincident with the term of the
6 President, or until the designation of a successor.

7 “(f) EXPENSES AND PER DIEM.—Members of the
8 Board shall serve without compensation, except that, while
9 serving on business of the Board away from their homes
10 or regular places of business, members may be allowed
11 travel expenses, including per diem in lieu of subsistence,
12 as authorized by section 5703 of title 5, United States
13 Code, for persons in the Government employed intermit-
14 tently.

15 “(g) MEETING.—

16 “(1) IN GENERAL.—The Board shall meet at
17 the call of the Chairperson (in consultation with the
18 other members of the Board) not less than 4 times
19 each year to consider a specific agenda of issues, as
20 determined by the Chairperson in consultation with
21 the other members of the Board.

22 “(2) QUORUM.—Four members of the Board
23 (not more than 3 of whom may be of the same polit-
24 ical party) shall constitute a quorum for purposes of
25 conducting business.

1 “(h) FEDERAL ADVISORY COMMITTEE ACT.—The
 2 Board shall be exempt from the provisions of the Federal
 3 Advisory Committee Act (5 U.S.C. App.).

4 “(i) PERSONNEL.—

5 “(1) STAFF DIRECTOR.—The Board shall, with-
 6 out regard to the provisions of title 5, United States
 7 Code, relating to the competitive service, appoint a
 8 Staff Director who shall be paid at a rate equivalent
 9 to a rate established for the Senior Executive Serv-
 10 ice under section 5382 of title 5, United States
 11 Code.

12 “(2) STAFF.—

13 “(A) IN GENERAL.—The Board may em-
 14 ploy, without regard to chapter 31 of title 5,
 15 United States Code, such officers and employ-
 16 ees as are necessary to administer the activities
 17 to be carried out by the Board.

18 “(B) FLEXIBILITY WITH RESPECT TO
 19 CIVIL SERVICE LAWS.—

20 “(i) IN GENERAL.—The staff of the
 21 Board shall be appointed without regard to
 22 the provisions of title 5, United States
 23 Code, governing appointments in the com-
 24 petitive service, and, subject to clause (ii),
 25 shall be paid without regard to the provi-

1 sions of chapters 51 and 53 of such title
 2 (relating to classification and schedule pay
 3 rates).

4 “(ii) MAXIMUM RATE.—In no case
 5 may the rate of compensation determined
 6 under clause (i) exceed the rate of basic
 7 pay payable for level IV of the Executive
 8 Schedule under section 5315 of title 5,
 9 United States Code.

10 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
 11 are authorized to be appropriated, out of the Federal Sup-
 12 plemental Medical Insurance Trust Fund established
 13 under section 1841, and the general fund of the Treasury,
 14 such sums as are necessary to carry out the purposes of
 15 this section.”.

16 (b) CONFORMING REFERENCES TO PREVIOUS PART
 17 D.—

18 (1) IN GENERAL.—Any reference in law (in ef-
 19 fect before the date of enactment of this Act) to part
 20 D of title XVIII of the Social Security Act is deemed
 21 a reference to part E of such title (as in effect after
 22 such date).

23 (2) SECRETARIAL SUBMISSION OF LEGISLATIVE
 24 PROPOSAL.—Not later than 6 months after the date
 25 of enactment of this section, the Secretary of Health

1 and Human Services shall submit to the appropriate
2 committees of Congress a legislative proposal pro-
3 viding for such technical and conforming amend-
4 ments in the law as are required by the provisions
5 of this section.

6 (c) EFFECTIVE DATE.—

7 (1) IN GENERAL.—The amendment made by
8 subsection (a) shall take effect on the date of enact-
9 ment of this Act.

10 (2) IMPLEMENTATION.—Notwithstanding any
11 provision of part D of title XVIII of the Social Secu-
12 rity Act (as added by subsection (a)), the Secretary
13 of Health and Human Services shall implement the
14 Voluntary Medicare Outpatient Prescription Drug
15 Discount and Security Program established under
16 such part in a manner such that—

17 (A) benefits under such part for eligible
18 beneficiaries (as defined in section 1860 of such
19 Act, as added by such subsection) with annual
20 incomes below 200 percent of the poverty line
21 (as defined in such section) are available to
22 such beneficiaries not later than the date that
23 is 6 months after the date of enactment of this
24 Act; and

1 (B) benefits under such part for other eli-
 2 gible beneficiaries are available to such bene-
 3 ficiaries not later than the date that is 1 year
 4 after the date of enactment of this Act.

5 **SEC. 3. ADMINISTRATION OF VOLUNTARY MEDICARE OUT-**
 6 **PATIENT PRESCRIPTION DRUG DISCOUNT**
 7 **AND SECURITY PROGRAM.**

8 (a) ESTABLISHMENT OF CENTER FOR MEDICARE
 9 PRESCRIPTION DRUGS.—There is established, within the
 10 Centers for Medicare & Medicaid Services of the Depart-
 11 ment of Health and Human Services, a Center for Medi-
 12 care Prescription Drugs. Such Center shall be separate
 13 from the Center for Beneficiary Choices, the Center for
 14 Medicare Management, and the Center for Medicaid and
 15 State Operations.

16 (b) DUTIES.—It shall be the duty of the Center for
 17 Medicare Prescription Drugs to administer the Voluntary
 18 Medicare Outpatient Prescription Drug Discount and Se-
 19 curity Program established under part D of title XVIII
 20 of the Social Security Act (as added by section 2).

21 (c) DIRECTOR.—

22 (1) APPOINTMENT.—There shall be in the Cen-
 23 ter for Medicare Prescription Drugs a Director of
 24 Medicare Prescription Drugs, who shall be appointed

1 by the President, by and with the advice and consent
2 of the Senate.

3 (2) RESPONSIBILITIES.—The Director shall be
4 responsible for the exercise of all powers and the dis-
5 charge of all duties of the Center for Medicare Pre-
6 scription Drugs and shall have authority and control
7 over all personnel and activities thereof.

8 (d) PERSONNEL.—The Director of the Center for
9 Medicare Prescription Drugs may appoint and terminate
10 such personnel as may be necessary to enable the Center
11 for Medicare Prescription Drugs to perform its duties.

12 **SEC. 4. EXCLUSION OF PART D COSTS FROM DETERMINA-**
13 **TION OF PART B MONTHLY PREMIUM.**

14 Section 1839(g) of the Social Security Act (42 U.S.C.
15 1395r(g)) is amended—

16 (1) by striking “attributable to the application
17 of section” and inserting “attributable to—

18 “(1) the application of section”;

19 (2) by striking the period and inserting “;
20 and”; and

21 (3) by adding at the end the following new
22 paragraph:

23 “(2) the Voluntary Medicare Outpatient Pre-
24 scription Drug Discount and Security Program
25 under part D.”.

1 **SEC. 5. MEDIGAP REVISIONS.**

2 Section 1882 of the Social Security Act (42 U.S.C.
3 1395ss) is amended by adding at the end the following
4 new subsection:

5 “(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL
6 POLICIES.—

7 “(1) PROMULGATION OF MODEL REGULA-
8 TION.—

9 “(A) NAIC MODEL REGULATION.—If,
10 within 9 months after the date of enactment of
11 the Medicare Rx Drug Discount and Security
12 Act of 2002, the National Association of Insur-
13 ance Commissioners (in this subsection referred
14 to as the ‘NAIC’) changes the 1991 NAIC
15 Model Regulation (described in subsection (p))
16 to revise the benefit package classified as ‘J’
17 under the standards established by subsection
18 (p)(2) (including the benefit package classified
19 as ‘J’ with a high deductible feature, as de-
20 scribed in subsection (p)(11)) so that—

21 “(i) the coverage for outpatient pre-
22 scription drugs available under such ben-
23 efit package is replaced with coverage for
24 outpatient prescription drugs that com-
25 plements but does not duplicate the bene-
26 fits for outpatient prescription drugs that

1 beneficiaries are otherwise entitled to
2 under this title;

3 “(ii) a uniform format is used in the
4 policy with respect to such revised benefits;
5 and

6 “(iii) such revised standards meet any
7 additional requirements imposed by the
8 Medicare Rx Drug Discount and Security
9 Act of 2002;

10 subsection (g)(2)(A) shall be applied in each
11 State, effective for policies issued to policy hold-
12 ers on and after January 1, 2004, as if the ref-
13 erence to the Model Regulation adopted on
14 June 6, 1979, were a reference to the 1991
15 NAIC Model Regulation as changed under this
16 subparagraph (such changed regulation referred
17 to in this section as the ‘2004 NAIC Model
18 Regulation’).

19 “(B) REGULATION BY THE SECRETARY.—
20 If the NAIC does not make the changes in the
21 1991 NAIC Model Regulation within the 9-
22 month period specified in subparagraph (A), the
23 Secretary shall promulgate, not later than 9
24 months after the end of such period, a regula-
25 tion and subsection (g)(2)(A) shall be applied in

1 each State, effective for policies issued to policy
2 holders on and after January 1, 2004, as if the
3 reference to the Model Regulation adopted on
4 June 6, 1979, were a reference to the 1991
5 NAIC Model Regulation as changed by the Sec-
6 retary under this subparagraph (such changed
7 regulation referred to in this section as the
8 ‘2004 Federal Regulation’).

9 “(C) CONSULTATION WITH WORKING
10 GROUP.—In promulgating standards under this
11 paragraph, the NAIC or Secretary shall consult
12 with a working group similar to the working
13 group described in subsection (p)(1)(D).

14 “(D) MODIFICATION OF STANDARDS IF
15 MEDICARE BENEFITS CHANGE.—If benefits
16 under part D of this title are changed and the
17 Secretary determines, in consultation with the
18 NAIC, that changes in the 2004 NAIC Model
19 Regulation or 2004 Federal Regulation are
20 needed to reflect such changes, the preceding
21 provisions of this paragraph shall apply to the
22 modification of standards previously established
23 in the same manner as they applied to the
24 original establishment of such standards.

1 “(2) CONSTRUCTION OF BENEFITS IN OTHER
2 MEDICARE SUPPLEMENTAL POLICIES.—Nothing in
3 the benefit packages classified as ‘A’ through ‘I’
4 under the standards established by subsection (p)(2)
5 (including the benefit package classified as ‘F’ with
6 a high deductible feature, as described in subsection
7 (p)(11)) shall be construed as providing coverage for
8 benefits for which payment may be made under part
9 D.

10 “(3) APPLICATION OF PROVISIONS AND CON-
11 FORMING REFERENCES.—

12 “(A) APPLICATION OF PROVISIONS.—The
13 provisions of paragraphs (4) through (10) of
14 subsection (p) shall apply under this section,
15 except that—

16 “(i) any reference to the model regu-
17 lation applicable under that subsection
18 shall be deemed to be a reference to the
19 applicable 2004 NAIC Model Regulation or
20 2004 Federal Regulation; and

21 “(ii) any reference to a date under
22 such paragraphs of subsection (p) shall be
23 deemed to be a reference to the appro-
24 priate date under this subsection.

1 “(B) OTHER REFERENCES.—Any reference
2 to a provision of subsection (p) or a date appli-
3 cable under such subsection shall also be con-
4 sidered to be a reference to the appropriate pro-
5 vision or date under this subsection.”.

